MASSACHUSETTS COMPARECARE WEBSITE
COST ESTIMATES METHODOLOGY

MAY 2023

SECTION 1: OVERVIEW OF CHIA AND APCD DATA

The Center for Health Information and Analysis (CHIA) is an independent state agency charged with monitoring the Massachusetts health care system. CHIA's mission is to be the agency of record for Massachusetts health care information, to responsibly steward sensitive and confidential data, and to objectively report reliable and meaningful information about the quality, affordability, utilization, access, and outcomes of the Massachusetts health care system.

Our vision is a transparent health care system where reliable information provides common ground for improvement and empowers people and organizations to make informed decisions. CHIA offers a variety of data and analytic products to support continual improvements in health care quality, affordability, access, and outcomes. The Massachusetts All-Payer Claims Database (MA APCD) is critical to this effort, enabling CHIA and its partners and customers to pursue a wide variety of projects, including complex research and analyses that support state agency operations and enhance the ability of payers and providers to deliver care.

The MA APCD is the most comprehensive source of health claims data from public and private payers in Massachusetts. With information on the majority of Massachusetts residents, the MA APCD promotes transparency, and affords a deep understanding of the Massachusetts health care system.

CHIA's enabling statute allows for the collection of data from commercial payers, third party administrators and public programs (Medicare and MassHealth, Massachusetts' Medicaid and Children's Health Insurance Program (CHIP) combined into one program). These data sets come both from medical insurers and from specialty insurers and administrators of "carved-out" services including pharmacy, mental health/chemical dependency, dental, and vision. It is used by health care providers, health plans, researchers, and others to address a wide variety of issues, including price variation, population health and quality measurement.

Section 2: Overview of Methodology

The cost estimate feature of the **Massachusetts CompareCare** website allows users to compare historical provider-specific cost estimates for select outpatient health care services either by payer (insurer) or through a consolidated all payer cost estimate option. Health care service cost estimates were derived using the MA APCD's commercial, fee-for-service, medical claims data for Massachusetts residents and non-residents from the following payers: Aetna, Anthem, Blue Cross Blue Shield of Massachusetts (BCBS), Boston Medical Center HealthNet Plan (BMCHP), Cigna, Fallon, Harvard Pilgrim Health Care (HPHC), Health New England (HNE), Mass General Brigham Health Plan, Tufts Health Plan, Tufts Health Plan - Direct (formerly Network Health) , UniCare, United Healthcare, and the United Healthcare & Harvard Pilgrim Health Care Alliance with service dates in calendar year 2021. MassHealth and its associated Managed Care Organizations (MCOs), original Medicare claims, and most claims for enrollees in employer self-insured plans were not included in the development of the cost estimates. Cost estimates are available for providers located in Massachusetts, as well as neighboring states including Connecticut, New Hampshire, Rhode Island. and Vermont.

Costs were estimated for a select set of outpatient services from each of the providers that rendered them. Cost estimates were calculated as the median service encounter cost for each service rendered by the provider, either for a single payer or median cost calculated across all eight payers. The cost included the amount the payer paid to the provider as well as the member cost sharing amounts (i.e. co-payment, coinsurance, and deductible) for each health care service. The median was determined to be the best estimate of service cost as it is less affected by outlier payments to providers. Cost estimates were intended to reflect the cost of typical, non-complicated encounters for services rendered by each provider.

Section 3: Data Specifications

Cost estimates for each provider of a defined set of outpatient services were developed from MA APCD medical claims data. Details on the methodology are described below.

Services

Cost estimates were developed for the following types of services: ambulance/transportation, behavioral health, colonoscopy and endoscopy, emergency room (ER) visits, eye exams, labs, maternity, office visits, physical and occupational therapy, and radiology. Services were defined using Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes which were sourced from the procedure code field on the MA APCD medical claims. For some services, restrictions were placed on procedure code modifiers in order to exclude potential outlier service encounters (e.g., increased procedural services related to maternity). For a full list of services available on the website and more detail on service definitions see Appendix 1.

Service Encounters

Service cost estimates for each provider were derived from the cost for individual service encounters with the provider. The cost for an encounter included the amount the payer paid to the provider as well as the patient cost sharing amounts. It was calculated as the sum of allowed amounts from claim lines that represented the service encounter, where claim line allowed amounts were generally defined as:

Allowed Amount = [Paid Amount + Copayment Amount + Coinsurance Amount + Deductible Amount + Withhold]

For each reported service, a single service encounter was unique to a member and date of service, based on claims from a single payer, and tied to a single primary provider. For lab, radiology, and colonoscopy and endoscopy services, each encounter was tied to a single primary provider that billed for the service. For all other services, each encounter was tied to a single primary servicing provider. Where services included, for example, add-on components or comprised separate technical and professional components, all component claims were bundled into a single service encounter and associated with the primary provider of the service.

For some service encounters (e.g., a laboratory service for Complete Blood Count), the allowed amount from a single claim line represented the total cost for the encounter. For other service encounters, the allowed amounts from multiple claim lines represented the total cost for the encounter. In the case of add-on components, the claim lines and corresponding claim allowed amounts for the primary service and the add-on component were bundled together into the same service encounter representing the primary service and tied to the primary provider of the service. When a procedure included a technical component (e.g. the cost for an X-Ray at a hospital) and a professional component (e.g., the cost for the radiologist to interpret the X-Ray), the professional component claim line was bundled with and added to the costs for the technical component, producing the total cost for that service encounter, and the encounter was tied to the provider of the technical component.

Typically, the professional component of a service is billed using the same service code billed by the primary provider of a service. Therefore, an approach was developed to separately identify the claim line corresponding to the professional portion of the service. For certain services, where the physician provided only the supervision or interpretation portion of the service, professional component claim lines were identified by procedure code modifier 26 accompanying the CPT code. For other services such as colonoscopies, where a physician performed the service and there was a separate facility fee billed as well, the claim line from the physician was treated as the professional component of the service encounter. For services such as these that included a separate professional component, the provider of the professional portion of a service was not considered to be the primary provider for the encounter, and the professional costs were bundled into the primary service encounter. Further details on professional component determination are included in Appendix 1.

Cost Estimates

Cost estimates for each provider were calculated as the median service encounter cost for each service rendered by the provider. These estimates were calculated separately for each payer and also calculated across all payers. For example, if Dr. Smith rendered a particular service 101 times to members in ABC Health Plan, Dr. Smith's ABC Health Plan cost estimate for that service would be the cost of the 51st service encounter, ranked in order of encounter cost. This method was implemented to minimize the effect of service encounters that, for various reasons, may cost substantially more or less than the average encounter (e.g., due to reduced rates for multiple services rendered on the same day, and reduced or increased levels of service).

For certain services, cost estimates were calculated on a per-unit basis rather than per-encounter. In these cases, a per-unit cost was calculated for each encounter, and service cost estimates were calculated as the median service encounter *per-unit* cost.

Only cost estimates meeting established threshold criteria were included in the final cost data set for the website. Service cost estimates had to be based on fifteen (eleven for maternity) or more service encounters and the 25th percentile for those service encounters had to be at least $1. Additionally, cost estimates were excluded if they were less than 10% of the median estimate for the service.

Providers

Providers presented in the cost section of the website were limited to those located in Massachusetts, New Hampshire, Connecticut, Rhode Island, or Vermont that rendered the select outpatient services in CY2021. Additionally, providers were excluded if they were a Veteran's Administration (VA) Hospital, End-stage Renal Disease (ESRD) treatment provider, state facility, or residential facility. Standardized provider information, including name, address and specialty/type, was obtained as described below.

The Health Insurance Portability and Accountability Act (HIPAA) mandated that all health care providers be assigned a unique ten digit identification number called a National Provider Identifier (NPI). Servicing providers and their associated billing entities were identified by the NPIs submitted on the MA APCD medical claims. Note that the NPIs were sourced directly from the submitted claims, not from the Provider File also submitted to the MA APCD as reference data unless they were missing on the claim.

A reference file from the National Plan and Provider Enumeration System (NPPES), the NPI Registry, which is administered by the Centers for Medicaid and Medicare Services (CMS), was used to obtain provider taxonomy (i.e. specialty and provider type) codes, name and practice address associated with each NPI. Information available in NPPES is supplied by providers themselves.

Taxonomy codes were used to classify providers into broader provider types for the cost section of the website, leveraging taxonomy code groupings established in the National Uniform Claim Committee's (NUCC's) Health Care Provider Taxonomy code set. Frequently, providers had more than one taxonomy code listed in NPPES. To capture a single provider taxonomy code, the taxonomy code identified by the provider as primary in NPPES was used. In cases where a provider did not specify a taxonomy code as primary, the first code listed in NPPES was used.

Since servicing providers can be associated with more than one billing entity or provider (e.g. a doctor who practices at multiple group practices), for the benefit of the consumer each servicing provider was presented under only one billing entity in the cost section of the website. An algorithm was developed to assign servicing providers with multiple billing entities to a single billing provider. The algorithm prioritized criteria such as claims activity in the second half of CY2021, the volume of services, organizations as opposed to individual providers, and matching billing and servicing provider address. When service cost estimates met the criteria for inclusion (described in Section 3 – Cost Estimates) under only a single billing provider, cost estimates were restricted to service encounters for the servicing provider under that billing provider. When a servicing provider's cost estimates met the criteria for inclusion under more than one billing provider, the cost estimates were based instead on all encounters for that servicing provider, regardless of billing provider. This generally was more prevalent with behavioral health, eye, and physical and occupational therapy providers. In all cases, the servicing provider was associated with the single anchor billing provider for display on the website.

Claims Data Sourcing

Cost estimates provided on this website were developed using the MA APCD. Specifically, data was sourced from MA APCD, using medical claims with service (incurred) dates of January 1, 2021 through December 31, 2021 paid through September 30, 2022. The cost estimates were derived using "final version", primary paid, fee-for-service medical claim lines for fully- and some self-insured commercial (i.e. non Medicaid and Medicare) members. Medical claims for select procedures which were performed on an outpatient basis from the following payers were used: Aetna, Anthem, Blue Cross Blue Shield of Massachusetts (BCBS), Boston Medical Center HealthNet Plan (BMCHP), Cigna, Fallon, Harvard Pilgrim Health Care (HPHC), Health New England (HNE), Mass General Brigham Health Plan, Tufts Health Plan, Tufts Health Plan - Direct, UniCare, United Healthcare, and United Healthcare & Harvard Pilgrim Health Care Alliance. More detail on the inclusion criteria is provided below:

- Medical claims can be adjusted by the payers several times before the final payment is made to a provider. Only the final version of each paid claim line was used in the development of the cost estimates, which eliminated interim adjusted claim records resulting in more accurate cost estimates. The term “final version” claim line refers to the latest version of a medical claim line that was paid by the payer. Within the APCD Medical Claims data, these claim lines were identified by Version Indicator =1.
- Only primary paid medical claims were included in the cost estimates. This ensured that partial payments by secondary payers were not included. Within the APCD Medical Claims data, these claim lines were identified by Claim Status=01,1.
- Fee-for-service claim lines were included because the payment amounts on these claim lines reflected actual payments to the providers. Capitated claim lines were not included because the payment amounts on these records were populated with “fee-for-service” equivalent amounts or proxies for payments to providers who actually received monthly capitated payments from a payer(s) for their services. Within the APCD Medical Claims data, fee-for-service claim lines were defined as those not under capitation, and identified by Capitated Encounter Flag = 2. (See Section 4 for additional information regarding carve-out vendor claims)
- Generally, only cost estimates for services performed on an outpatient basis were included in the current version of the website, with the exception of Professional Global Maternity. Type of Bill and Place of Service codes were used to determine outpatient claims. Within the APCD Medical Claims data, outpatient facility claim lines were identified by a Type of Bill value not equal to 11, 12, 18, 21, 22, 23, 41, 65, 66, 84, 86, and outpatient professional claim lines were identified by a Place of Service value not equal to 21, 31, 32, 33, 51, 54, 55, 56, 61.
- Only medical claims associated with commercial insurance products were used in the development of the cost estimates. Products included were Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point of Service (POS), and Exclusive Provider Organization (EPO). Medical claims paid by MassHealth, Medicare Advantage Plans, Original Medicare Parts A and B, and Medicaid Managed Care Organizations were excluded. Within the APCD Medical Claims data, these claim lines were identified by the claim Insurance Type / Code Product = 12, 13, 14, HM.
- Claim lines for certain services were excluded based on the procedure code modifier associated with the CPT code. See Appendix 1 for details.

Section 4: Payer-Specific Cleaning and Adjustments to the Methodology

While the above data specifications are meant to be uniform across payers, at times it was necessary to adapt payer-specific logic to certain aspects of the data specifications. Listed below are the payer specific nuances addressed, as well as some additional adjustments made to the data.

- Professional Fees
  - CMS issued guidance in 2019 that allowed professional fee claims for radiology and pathology services to report dates of service reflecting when review and interpretation was completed, rather than the encounter date. Professional fee claims for these services that were within 7 days of the encounter were bundled into the encounter.
- Billing and Servicing NPI
  - For all payers except Anthem, the rendering provider NPI was used as the servicing provider NPI. For Anthem claims, the servicing provider NPI was used directly.
  - For all payers, if the billing provider NPI reflected an individual and the servicing provider NPI an organization (after applying the above adjustments), servicing provider NPI replaced the billing provider NPI.
- Allowed Amount Calculation Adjustments
  - For Aetna claims that indicated the claim was amended (using the Claim Line Type field), the claim line allowed amounts were defined using the allowed amount field directly.
  - Blue Cross Blue Shield has an Alternative Quality Contract arrangement with Atrius Health. Some claims for services under this arrangement were missing payer paid amounts, which produced erroneous cost estimates. Cost estimates for non-lab services billed by Atrius Health to Blue Cross Blue Shield were excluded if they were less than half the median estimate for the service across all payers and providers.

Appendix 1: Service Categories

SERVICE CATEGORY		PRIMARY SERVICE CODES	SERVICE SPECIFIC INFORMATION
Ambulance/ Transportation Services		A0425, A0426, A0427, A0428, A0429, A0433, A0434	- A0425 (ambulance mileage) costs are reported per unit, rather than per encounter. - Because multiple trips frequently occur on the same day, procedure code modifier, in combination with the primary service code, were used to uniquely define an encounter.
Behavioral Health	Diagnostic Evaluation	90791, 90792	
Behavioral Health	Health and Behavioral Assessment/ Intervention	96150, 96151, 96152, 96153, 96154, 96155	- Costs are reported per unit, rather than per encounter.
Behavioral Health	Testing and Evaluation	96101, 96102, 96103, 96105, 96111, 96116, 96118, 96119, 96120	- Psychological testing (96101, 96102, 96103), assessment of aphasia (96105), neurobehavioral status exam (96116), and neuropsychological testing (96118, 96119) costs are reported per unit, rather than per encounter.
Behavioral Health	Psychotherapy	90832, 90834, 90837, 90847, 90853	
Colonoscopy and Endoscopy	Colonoscopy	45378, 45380, G0105, G0121	- Colonoscopy and endoscopy services are reported under the primary provider that billed for the service. - 45383, 45384 and 45385 (polypectomy) are codes commonly billed with colonoscopies. Where this occurs, these are bundled into the total cost for the colonoscopy, and the service is identified as occurring with a polypectomy. - While not reported separately, anesthesia costs (00100 – 01999), where applicable, are bundled into the total cost for colonoscopies. - If an endoscopy occurred on the same day as a colonoscopy service, costs for the endoscopy were bundled into the total cost for the colonoscopy, and the service is identified as occurring with an endoscopy. Any associated professional component fees were also bundled into the total cost. - Services submitted on professional claims, where the servicing provider was not an ASC and the modifier was not ‘SG’, were treated as professional component fees. (Ambulatory Surgical Centers often bill facility charges on professional claims using modifier ‘SG’). Additionally, if these claims indicated an “office” setting

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			for the procedure and did not co-occur with a separate facility bill (e.g., procedures at certain large, non-facility sites), they were treated as the primary service encounter as these claims represented the full procedure cost.
Colonoscopy and Endoscopy	Endoscopy	43239	- Colonoscopy and endoscopy services are reported under the primary provider that billed for the service. - While not reported separately, anesthesia costs (00100 – 01999), where applicable, are bundled into the total cost for endoscopies. - If a colonoscopy occurred on the same day as an endoscopy service, costs for the colonoscopy were bundled into the total cost for the endoscopy, and the service is identified as occurring with a colonoscopy. Any associated professional component fees were also bundled into the total cost. - Services submitted on professional claims, where the servicing provider was not an ASC and the modifier was not 'SG', were treated as professional component fees. (Ambulatory Surgical Centers often bill facility charges on professional claims using modifier 'SG'). Additionally, if these claims indicated an "office" setting for the procedure and did not co-occur with a separate facility bill (e.g., procedures at certain large, non-facility sites), they were treated as the primary service encounter as these claims represented the full procedure cost.
ER Visits		99281, 99282, 99283, 99284, 99285	- Services submitted on professional claims were treated as professional component fees. - Service codes were processed together as a group within the same service encounter, as the code billed for the professional component may not be the same as the primary service code. The service reported reflects that from the primary provider. - Claim lines with the following modifiers were excluded from the data: AS,FX,FY,SA,22,23,47,50,51,52,53,54,55,56,62,66,73,78,80,81,82.
Eye Exams		92002, 92004, 92012, 92014	- Services submitted on professional claims, where the servicing provider was an individual and there was an associated facility claim line, were treated as professional component fees.

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			- Service codes were processed together as a group within the same service encounter, as the code billed for the professional component (in cases where there is also a facility fee) may not be the same as the primary service code. The service reported reflects that from the primary provider.
Labs	Blood Tests	80051, 80061, 80069, 80074, 80076, 82040, 82105, 82150, 82306, 82310, 82378, 82435, 82465, 82533, 82550, 82565, 82607, 82627, 82728, 82785, 82947, 82977, 83036, 83525, 83540, 83550, 83615, 83690, 83721, 83735, 83970, 84075, 84100, 84146, 84153, 84155, 84165, 84295, 84402, 84403, 84436, 84439, 84443, 84450, 84460, 84478, 84479, 84480, 84481, 84520, 84550, 84703, 85025, 85027, 85610, 85651, 86003, 86038, 86140, 86141, 86430, 86480, 86618, 86695, 86696, 86703, 86706, 86787, 86800, 86803, 86900, 86901, 87340	- Lab services are reported under the primary provider that billed for the service. - 86003 (immunology: allergen specific IgE) costs are reported per unit, rather than per encounter.
Labs	Pap Test (Pap Smear)	88142, 88175	- Lab services are reported under the primary provider that billed for the service.
Labs	Swab Tests	87070, 87077, 87081, 87186, 87205, 87400, 87430, 87491, 87591, 87624, 87880	- Lab services are reported under the primary provider that billed for the service. - Bacterial culture, aerobic isolate (87077), microdilution or agar dilution (87186), and influenza A or B testing (87400) costs are reported per unit, rather than per encounter.
Maternity	Global Physician Obstetric Care	59400, 59510	- Global OB codes bundle costs associated with routine obstetric care (including antepartum care), delivery (vaginal or cesarean), and postpartum care. These services are usually billed on the baby's date of birth and therefore are billed as having an inpatient

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			place of service. These are the only services with an inpatient place of service. - Claim lines with modifiers were excluded from the data.
Office Visits	Consultation	99241, 99242, 99243, 99244, 99245	- Claim lines with the following modifiers were excluded from the data: AS,FX,FY,SA,22,23,47,50,51,52,53,54,55,56,62,66,73, 78,80,81,82.
Office Visits	Presenting with a problem	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215	- Claim lines with the following modifiers were excluded from the data: AS,FX,FY,SA,22,23,47,50,51,52,53,54,55,56,62,66,73, 78,80,81,82.
Office Visits	Preventive Care	99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397	- Claim lines with the following modifiers were excluded from the data: AS,FX,FY,SA,22,23,47,50,51,52,53,54,55,56,62,66,73, 78,80,81,82.
Physical and Occupational Therapy	Occupational Therapy	97003, 97004, 97535, 97750, 97760, 97762	- Self-care/home management training (97535), physical performance test or measurement (97750), and orthotic/prosthetic management (97760, 97762) costs are reported per unit, rather than per encounter.
Physical and Occupational Therapy	Physical Therapy	97001, 97002, 97012, 97016, 97110, 97112, 97116, 97124, 97140, 97150, 97530	- Most therapeutic procedure (97110, 97112, 97116, 97124, 97140, and 97530) costs are reported per unit, rather than per encounter.
Radiology	CT Scan	70450, 70460, 70470, 70480, 70481, 70486, 70487, 70490, 70491, 71250, 71260, 71270, 72125, 72128, 72131, 72132, 72192, 72193, 73200, 73201, 73700, 73701, 74150, 74160, 74170, 74176, 74177, 74178, 76380	- Radiology services are reported under the primary provider that billed for the service.
Radiology	CTA	70496, 70498, 71275, 74174, 74175, 75574	- Radiology services are reported under the primary provider that billed for the service.
Radiology	Bone Density Scan (DEXA)	77080	- Radiology services are reported under the primary provider that billed for the service.
Radiology	Mammography	77065, 77066, 77067	- Radiology services are reported under the primary provider that billed for the service.

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Radiology	MRA (Magnetic Resonance Angiography)	70544, 70546, 70547, 70548, 70549, 71555, 72198, 73725, 74185	- Radiology services are reported under the primary provider that billed for the service.
Radiology	MRI (Magnetic Resonance Imaging)	70336, 70540, 70543, 70551, 70553, 71550, 71552, 72141, 72146, 72148, 72156, 72157, 72158, 72195, 72197, 73218, 73220, 73221, 73222, 73223, 73718, 73720, 73721, 73722, 73723, 74181, 74183, 77059	- Radiology services are reported under the primary provider that billed for the service. - When 74183 (MRI of abdomen) and 72197 (MRI of pelvis) occur together, they are combined into a new service of MR Enterography.
Radiology	Nuclear Medicine	78014, 78018, 78070, 78226, 78227, 78264, 78306, 78315, 78320, 78472, 78707, 78708	- Radiology services are reported under the primary provider that billed for the service.
Radiology	PET/CT Scan	78814, 78815, 78816	- Radiology services are reported under the primary provider that billed for the service.
Radiology	Ultrasound	76642, 76700, 76705, 76816, 76830, 76856	- Radiology services are reported under the primary provider that billed for the service. - 76816 (pregnancy ultrasound, follow-up per fetus) costs are reported per unit, rather than per encounter.
Radiology	X-ray	71020, 72010, 72100, 73030, 73110, 73120, 73562, 73610, 73620, 73630	- Radiology services are reported under the primary provider that billed for the service.

Unless otherwise specified, claim lines with a procedure code modifier of 26 were treated as professional component fees.

Appendix 2: APCD Fields

NAME	MA APCD ELEMENT	RESTRICTIONS
OrgID	MC001	OrgIds corresponding to the included payers
Insurance Type /Code Product	MC003	12, 13, 14, HM
Version Indicator	Derived-MC10	1
Capitated Encounter Flag	MC081	2
Incurred Date	Derived-MC9	202101 – 202112
Type of Bill	MC036	Not equal to 11, 12, 18, 21, 22, 23, 41, 65, 66, 84, 86
Place of Service	MC037	Not equal to 21, 31, 32, 33, 51, 54, 55, 56, 61 (with exceptions for maternity)
Claim Status	MC038	01 or 1
Procedure Code	MC055	Select CPT and HCPCS codes
Type of Claim	MC094	001, 002
Servicing Provider NPI	MC026	See Section 3 – Providers
Billing Provider NPI	MC077	See Section 3 – Providers
Procedure Modifier 1	MC056	See Appendix 1
Paid Amount	MC063	N/A
Pre-Paid Amount	MC064	N/A
Copay Amount	MC065	N/A
Coinsurance Amount	MC066	N/A
Deductible Amount	MC067	N/A
Withhold Amount	MC116	N/A
Allowed Amount	MC098	N/A

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